Kate Donnally, LICSW

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CONSENT TO TREATMENT AGREEMENT

I acknowledge that I have received, have read (or have had read to me), and understand the Psychotherapy Services Agreement & Consent to Treat, Notice of Privacy Practices, and disclosure of Vermont State Statutes, regarding the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. In the event of terminating services, I understand that I will be responsible for paying for the services that I have already received.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not attend a scheduled session, I may be charged a fee up to that of the hourly rate for my session.

I am aware that an agent of my insurance company, other third-party payer, agent of a third-party billing service, or other third-party provider may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive for the purposes of treatment, payment, and healthcare operations. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

____ ___________________________

Signature of client (or person acting for client) — Date

____ ___________________________

Printed name — Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____ ___________________________

Signature of therapist — Date

• Copy accepted by client • Copy kept by therapist

This is a strictly confidential client medical record. Redisclosure or transfer is expressly prohibited by law.